

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 270

03192

270

## CERTIFICATE OF DEATH

Reg. Diat. No. ....

## 1. PLACE OF DEATH:

County..... Somerset  
City or town..... Crisfield

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?..... 3 years

Hospital, institution, or street address where death occurred:

McCreedy Memorial Hospital

How long in hospital or institution?..... 3 da

## 3. (a) FULL NAME

Robert Matsom Baylor

4. Sex

5. Color or race

6.(a) Single, married, widowed, or divorced

Male

White

Married

6.(b) Name of husband or wife..... Louise Phelps Baylor

7. Birth date of deceased (mo., day, yr.)

July 19 1883

6.(c) If alive, give age..... 61 years

8. AGE: Years

Months

Days

If less than one day

61

8

5

hrs.

min.

9. Birthplace.....

Charles Town, Jefferson, W. Va.

(Town, county, and state)

10. Usual occupation..... Pharmacist

11. Industry or business

FATHER

Tilden G Baylor

12. Name.....

Jefferson County, W. Va.

13. Birthplace

Sally Madison Beckwith

MOTHER

Jefferson County, W. Va.

14. Maiden name.....

15. Birthplace

Miss Anne Loyd Baylor

16. Informant.....

Chales Town, W. Va.

Address

Burial

(Burial, cremation, or removal. Which?)

Date thereof..... Mch, 26.1945  
(month) (day) (year)

Cemetery or crematory.....

Zion Episcopalian Cem.

Location.....

Charles Town, W. Va.

18. Funeral director.....

Address

3/26/45 19.....

(Date rec'd by registrar)

John A Bradshaw

Crossfield Drq

B.C. Collins, M.D.

Registrar

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State..... W. Va. County..... Jefferson

City or town..... Charles Town

(If outside city or town limits, write RURAL and give nearest town)

Street No..... (If rural, give LOCATION)

2.(a) If veteran, name war.....

## 3. (b) Social Security Number

## MEDICAL CERTIFICATION

20. DATE OF DEATH..... mch 24 1945 at 130 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from March. 19 1945 to march 24 1945

and that I last saw h..... alive on march 24 1945

Immediate cause of death..... adult &amp; old hand

Corona malignt Colletia

DURATION

Due to..... Carcinoma of Pancreas

metastasis in Liver &amp; Lung

Due to.....

Other conditions.....

(Include pregnancy within 3 months of death)

Major findings of operations.....

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

Where did injury occur? ..... (City or town) (County) (State)

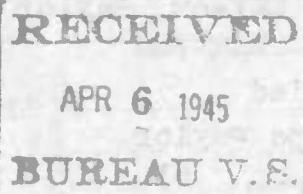
Injured at home, farm, industry, public place (where?) .....

Means of injury..... Injured at work?

23. SIGNATURE..... Drury C. Callahan, M.D.

M. D. or other

Address..... Maccioni St. 2nd..... Date signed mch. 25.45



## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 13193

03193

## CERTIFICATE OF DEATH

Reg. Dist. No. 260

1. PLACE OF DEATH:  
 County Somerset  
 City or town Princess Anne, Md.

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? half time

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

3. (a) FULL NAME

William James Davis4. Sex M 5. Color of race Colored 6. (a) Single, married, widowed, or divorced Married6. (b) Name of husband or wife H. Elizabeth Davis7. Birth date of deceased (mo., day, yr.) September, 15, 18758. AGE: Years 68 Months 6 Days  If less than one day  hrs.  min. 9. Birthplace Somerset Co.10. Usual occupation Farmer

11. Industry or business

12. Name not known

13. Birthplace

14. Maiden name Sarah Lovington15. Birthplace Somerset Co.16. Informant Gitteton DavisAddress Princess Anne, Md.17. Burial Date thereof 3-19-45  
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory John WesleyLocation Princess Anne, Md.18. Funeral director William James & SonAddress Princess Anne, Md.19. 3/16 1945  
(Date rec'd by registrar)

2. USUAL RESIDENCE (HOME) OF DECEASED:  
 (For newborn infants give residence of mother)

State ..... County .....

City or town ..... (If outside city or town limits, write RURAL and give nearest town)

Street No. ..... (If rural, give LOCATION)

2.(a) If veteran, name war .....

3. (b) Social Security Number

## MEDICAL CERTIFICATION

20. DATE OF DEATH March 13, 1945 at 6:00 p.m.21. I CERTIFY that death occurred on the date above stated; that I attended deceased Feb. 10, 1945 March 13, 1945 1945 1945 and that I last saw him/her alive on March 12, 1945 1945

Immediate cause of death

Chronic myocarditis 2 yrs.

Due to

Due to

Gastroststitial nephritis 1 yrs.

(Include pregnancy within 3 months of death)

Major findings or operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

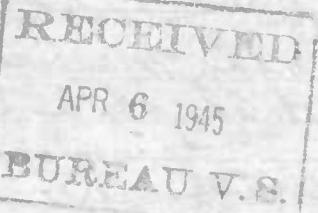
Accident, suicide, or homicide..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE E. G. Maysman M. D. or otherAddress Princess Anne, Md. Date signed 3-15-45



PLEASE WRITE PLAINLY, WITH UNFADING INK.  
Supply every item of information carefully. The correct age  
is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 3-2

## CERTIFICATE OF DEATH

03194

265

Reg. Dist. No.

## 1. PLACE OF DEATH:

County.....

Somerset  
Fairfield

City or town.....

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?.....

5-6 years

Hospital, institution, or street address where death occurred:.....

How long in hospital or institution?.....

## 3. (a) FULL NAME

William P Downing

4. Sex

5. Color or race

6.(a) Single, married, widowed, or divorced

Male Colored married

Olda Downing

6.(b) Name of husband or wife.....

6.(c) If alive, give age 62 years

7. Birth date of deceased (mo., day, yr.)

March 24, 1876

8. AGE:

Years  
39

Months

Days

If less than one day

hrs. min.

9. Birthplace.....

Hachan Neck Accomac Co Va.

(Town, county, and state)

10. Usual occupation.....

Oyster opener

11. Industry or business

12. Name.....

Charles Downing

13. Birthplace.....

Accomac Co Va

14. Maiden name.....

Charlotte Dowdy

15. Birthplace.....

Somewhere in Virginia

16. Informant.....

Olda Downing

Address.....

Fairfield Md

17. (Burial, cremation, or removal. Which?)

Date thereof Mar 19 1945  
(month) (day) (year)

Cemetery or crematory.....

Fairfield Cemetery

Location.....

Fairfield Md.

18. Funeral director.....

Chas H Ward

Address.....

Marion Sta Md

19. (Date rec'd by registrar)

3/16/45 19

E. Collins M.D.

Registrar

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State.....

Md

County.....

Somerset

City or town.....

(If outside city or town limits, write RURAL and give nearest town)

Street No.....

(If rural, give LOCATION)

2.(a) If veteran, name war.....

## 3. (b) Social Security Number

## MEDICAL CERTIFICATION

20. DATE OF DEATH.....

3/15 1945 at 6:35 AM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Feb. 27 1945 to 3/15 1945

and that I last saw him alive on Feb. 27 1945

Immediate cause of death.....

Cerebral Hemorrhage

Paralysis

Due to..... Cerebral Hemorrhage

Due to.....

Other conditions.....

(Include pregnancy within 8 months of death)

Major findings of operations.....

Date of op. ....

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide.....

Date of.....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury.....

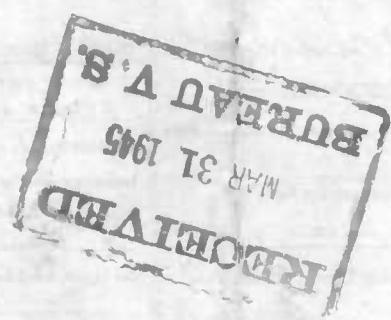
Injured at work? .....

23. SIGNATURE.....

W. G. Barkley, M.D.

M. D. or other

Address..... 309 W. Mich Ave Date signed 3/16/45



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## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 6

03195

## CERTIFICATE OF DEATH

Reg. Dist. No. 270

1. PLACE OF DEATH: Somerset  
County..... Crisfield  
City or town.....  
(If outside city or town limits, write RURAL and give nearest town) 2 da  
How long in above place of death?  
Hospital, institution, or street address where death occurred: McCready Memorial Hospital  
How long in hospital or institution?

3. (a) FULL NAME Anna Roena Evans

4. Sex Female	5. Color or race White	6. (a) Single, married, widowed, or divorced Married
T Roosevelt Evans		
6. (b) Name of husband or wife.....		
7. Birth date of deceased (mo., day, yr.) June 28 1908		
8. AGE: Years 36 Months 9 Days 0 If less than one day hrs. min.		
8. Birthplace Smith Island Somerset Maryland		
(Town, county, and state) Housewife		
10. Usual occupation.....		
11. Industry or business.....		
FATHER	12. Name..... Merrill Tyler	
	13. Birthplace Smith Island Md	
MOTHER	14. Maiden name..... Myrtie Evans	
	15. Birthplace Smith Island Md	
16. Informant..... T Roosevelt Evans		
Address Ewell Md		
17. Burial..... April 1 1945		
(Burial, cremation, or removal. Which?) Cemetery or crematory..... Ewell cemetery		
Location..... Smith Island Md		
18. Funeral director..... John A Bradshaw		
Address Crisfield Md		
19. Date rec'd by registrar..... 3/29/45		

2. USUAL RESIDENCE (HOME) OF DECEASED:  
(For newborn infants give residence of mother)

State..... Md	County..... Somerset
City or town..... Ewell Md	
(If outside city or town limits, write RURAL and give nearest town)	
Street No.....	
(If rural, give LOCATION)	
2.(a) If veteran, name war.....	

3. (b) Social Security Number

MEDICAL CERTIFICATION

20. DATE OF DEATH..... March 28 1945 at 12:15 A.M.

21. I CERTIFY that death occurred on the date above stated: That I attended deceased from March 26 1945 to March 25 1945 and that I last saw her alive on March 27 1945.

Immediate cause of death..... Pericarditis - septic

Due to..... Hemorrhage pulmonary 10pm

Due to..... Carditis well 18 yrs

Other conditions..... Hemorr. colitis 15 yrs

(Include pregnancy within 3 months of death)

Major findings or operations.....

Date of op.....

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

Where did injury occur?..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?).....

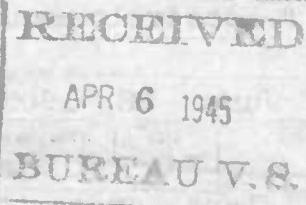
Means of Injury..... Injured at work?

23. SIGNATURE..... Dr. Wm. Peyton M.D.

M. D. or other.....

Address..... Crisfield Md

Date signed..... March 29



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## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 77

03196

## CERTIFICATE OF DEATH

Reg. Dist. No.

260

## 1. PLACE OF DEATH:

County SomersetCity or town Princess Anne, Md.

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, Institution, or street address where death occurred:

How long in hospital or institution?

## 3. (a) FULL NAME

John B. Fleming4. Sex M 5. Color or race W 6. (a) Single, married, widowed, or divorced Married6. (b) Name of husband or wife Saura E. Fleming7. Birth date of deceased (mo., day, yr.) Nov. 5, 1855 6. (c) If alive, give age 55 years8. AGE: Years 89 Months 4 Days 24 If less than one day \_\_\_\_\_ hrs. \_\_\_\_\_ min.9. Birthplace Princess Anne, Md. (Town, county, and state)10. Usual occupation Retired Farmer

## 11. Industry or business

12. Name Wellman S. Fleming13. Birthplace Princess Anne, Md.14. Maiden name Mary E. Wickerson15. Birthplace Princess Anne, Md.16. Informant Mrs Saura E. FlemingAddress Princess Anne, Md.17. Burial (Burial, cremation, or removal. Which?) Burial Date thereof April 1, 1948

(month) (day) (year)

Cemetery or crematory Presbyterian CemeteryLocation Princess Anne, Md.18. Funeral director Wade MarshallAddress Princess Anne, Md.19. 3/31 1948 of lung

(Date rec'd by registrar) (Cause of death)

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County SomersetCity or town Princess Anne, Md. (If outside city or town limits, write RURAL and give nearest town)

Street No. \_\_\_\_\_ (If rural, give LOCATION)

2.(a) If veteran, name war \_\_\_\_\_

## 3. (b) Social Security Number

none

## MEDICAL CERTIFICATION

20. DATE OF DEATH March 30th 1948 at \_\_\_\_\_ M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

and that I last saw h. \_\_\_\_\_ alive on 19. to 19.

Immediate cause of death Death wif. of Head DURATION shortDue to Tuberculosis

Due to \_\_\_\_\_

Other conditions \_\_\_\_\_

(Include pregnancy within 8 months of death)

## Major findings or operations

Date of op. \_\_\_\_\_

## Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

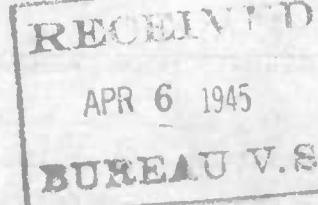
Accident, suicide, or homicide \_\_\_\_\_ Date of \_\_\_\_\_

Where did injury occur? \_\_\_\_\_ (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury \_\_\_\_\_ Injured at work? \_\_\_\_\_

23. SIGNATURE G. Smith M. D. or other \_\_\_\_\_Address Baltimore, Md. Date signed 3/31/48



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 2

03197

## CERTIFICATE OF DEATH

Reg. Dist. No. 270

## 1. PLACE OF DEATH:

County ..... Somerset  
 City or town ..... Crisfield  
 (If outside city or town limits, write RURAL and give nearest town) 2 da

How long in above place of death?

Hospital, institution, or street address where death occurred:

McCready Memorial Hospital  
 2 da

How long in hospital or institution?

## 3. (a) FULL NAME

Esther Lorrain French

## 3. (b) Social Security Number

## 4. Sex

Female

## 5. Color or race

White

## 6. (a) Single, married, widowed, or divorced

Single

## 6. (b) Name of husband or wife

7. Birth date of deceased (mo., day, yr.)

Dec 23 1945

5. (c) If alive, give age years

## 8. AGE:

1

Years

2

Months

15

Days

If less than one day

hrs.

min.

## 9. Birthplace

Rumbley Somerset Maryland

(Town, county, and state)

## 10. Usual occupation

## 11. Industry or business

## MOTHER FATHER

12. Name

John French

Rumbley Md

13. Birthplace

Esther Meredith

Frenchtown Md

14. Maiden name

Mrs John French

Frenchtown Md

15. Birthplace

Burial

Date thereof

McPherson 11945

(Burial, cremation, or removal. Which?)

(month) (day) (year)

Family cemetery

Cemetery or crematory

Frenchtown Md

Location

16. Informant

Address

Burial

(Burial, cremation, or removal. Which?)

(month) (day) (year)

Family cemetery

Cemetery or crematory

Frenchtown Md

Location

John A. Bradshaw

Address

Crisfield Md

3/9/45

(Date rec'd by registrar)

19.

6 E Collins M.D.

Registrar

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State ..... Md

City or town ..... Rumbley

(If outside city or town limits, write RURAL and give nearest town)

Street No. ....

(If rural, give LOCATION)

2.(a) If veteran, name war.....

Somerset

County ..... County

Rumbley

(If outside city or town limits, write RURAL and give nearest town)

Street No. ....

(If rural, give LOCATION)

2.(a) If veteran, name war.....

## MEDICAL CERTIFICATION

## 20. DATE OF DEATH

Mar 8

1945

10:00 AM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Mar 6

1945

to Mar 8

1945,

and that I last saw her alive on Mar 8

1945

## Immediate cause of death

Acute del of heart  
acute anemiaDue to Acute nephritis  
diabetic mellitus?

## Due to

## Other conditions

(Include pregnancy within 3 months of death)

## Major findings of operations

none

Date of op.

## Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

## 22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

## Where did injury occur?

(City or town)

(County)

(State)

## Injured at home, farm, industry, public place (where?)

## Means of Injury

Injured at work?

## 23. SIGNATURE George C. Brellwass

M. D. or other

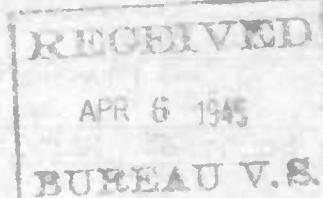
Address Munson Ob 2nd

Date signed Mar 9-45

RECEIVED BY THE UNITED STATES GOVERNMENT

BY THE ATTORNEY GENERAL

EX-1000-1000-1000



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physician, please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 95

03198

## CERTIFICATE OF DEATH

Reg. Dist. No. 260

## 1. PLACE OF DEATH:

County... Somerset

City or town... Eden

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? about 50 yrs.

Hospital, Institution, or street address where death occurred:

no no

How long in hospital or institution?

## 3. (a) FULL NAME

Nellie Bly Furness

4. Sex

5. Color or race

6.(a) Single, married, widowed, or divorced

Female

aa

married

8.(b) Name of husband or wife

George Furness

8.(c) If alive, give age years

7. Birth date of

deceased (mo., day, yr.)

about 1884

8. AGE:

Years

Months

Days

If less than one day

hrs. min.

9. Birthplace

Princess Anne, Somerset Co., Md.  
(Town, county, and state)

10. Usual occupation

Housewife

11. Industry or business

Home

12. Name

Fortune Woolford

13. Birthplace

Somerset Co., Maryland

14. Maiden name

Unknown

15. Birthplace

Unknown

16. Informant

George Furness

Address

Eden, Maryland

17. Burial

Date thereof Mar. 4-1945  
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory

Mount Calvary

Location

Brundland

18. Funeral director

James F. Stewart

Address

Salisbury and

19. Date rec'd by registrar

and 2 1945

Registrar

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State... md

County... Somerset

City or town... Eden md

(If outside city or town limits, write RURAL and give nearest town)

Street No... no

(If rural, give LOCATION)

no

2.(a) If veteran, name war...

## 3. (b) Social Security Number

no

## MEDICAL CERTIFICATION

20. DATE OF DEATH March 1 1945 AM 6 P M

21. I CERTIFY that death occurred on the date above stated; that deceased from

and that I last saw him alive on

Immediate cause of death

Acute dilatation of heart

DURATION

Due to

Due to

Other conditions

(Include pregnancy within 8 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

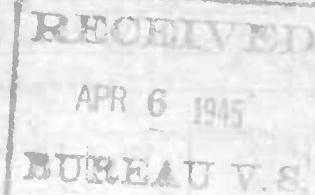
Injured at home, farm, industry, public place (where?)

Means of injury Death Neglect Escaped from work

23. SIGNATURE W.H. Woolford MD

M. D. or other

Address Princess Ann Md Date signed 3/2/45



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 19

## CERTIFICATE OF DEATH

03199

Reg. Dist. No. 270

**1. PLACE OF DEATH:** Somerset  
 County .....  
 City or town ..... Crisfield RURAL  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death? 2 da  
 Hospital, institution, or street address where death occurred: McCready Memorial Hospital  
 How long in hospital or institution?

**2. USUAL RESIDENCE (HOME) OF DECEASED:**  
 (For newborn infants give residence of mother)  
 State ..... MD ..... County ..... Somerset  
 City or town ..... Kingston  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No. .....  
 (If rural, give LOCATION)  
 2.(a) If veteran, name war

**3. (a) FULL NAME** Bettie Esther Gray

**3. (b) Social Security Number**

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Single

6.(b) Name of husband or wife.....

7. Birth date of deceased (mo., day, yr.) Dec 21 1942

6.(c) If alive, give age ..... years

8. AGE:	Years	Months	Days	If less than one day
	1	3	27	hrs. min.

9. Birthplace ..... Kingston Somerset Maryland  
 (Town, county, and state)

10. Usual occupation..... None

11. Industry or business

12. Name ..... Harvey Gray  
 13. Birthplace ..... Kingston Md14. Maiden name ..... Bettie Fry  
 15. Birthplace ..... Greensboro W Va16. Informant ..... Bettie Gray  
 Address ..... Kingston Md17. Burial ..... Date thereof ..... Mch 20 1945  
 (Burial, cremation, or removal. Which?) (month) (day) (year)  
 Cemetery or crematory ..... Holly Grove cemetery

Location ..... Westover R F D #1

18. Funeral director ..... John A Bradshaw  
 Address ..... Crisfield Md19. Date rec'd by registrar ..... 3/20 1945  
 (Date rec'd by registrar) *Aurilia P. Lawrence* *Deputy Registrar* *M. S. Collins M. D.*  
 Registrar

**MEDICAL CERTIFICATION**

20. DATE OF DEATH ..... *March 18 1945*

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from *March 15 1945* to *March 18 1945*, and that I last saw her alive on *March 15 1945*.

Immediate cause of death ..... *acute diag out*

Due to *due to absence of John A Bradshaw*  
*Cerebral*

Due to *hypertensive cerebral*  
*hemorrhage*

Other conditions .....  
 (Include pregnancy within 3 months of death)

Major findings of operations ..... *none*  
 Date of op. ....Autopsy results .....  
 PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide ..... Date of .....

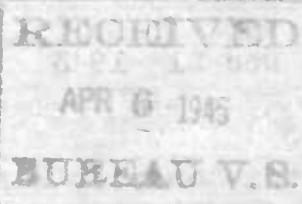
Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury ..... Injured at work?

23. SIGNATURE ..... *George O. Coulter*  
 M. D. or other .....  
 Address ..... *300 W. Lombard St. Baltimore 19*  
 Date signed ..... *March 20 1945*

DEPARTMENT OF JUSTICE  
FEDERAL BUREAU OF INVESTIGATION



**PLEASE WRITE PLAINLY, WITH UNFADING INK.** Supply every item of information carefully. The correct age is especially important. Physicians please write the causes of death clearly and legibly.

# MARYLAND STATE DEPARTMENT OF HEALTH

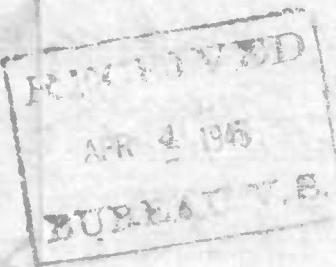
2411 N. Charles St., Baltimore 46

# CERTIFICATE OF DEATH

Reg. Dist. No. 26

269

1. PLACE OF DEATH: County... <u>Somerset</u> City or town... <u>Oriole Md.</u> (If outside city or town limits, write RURAL and give nearest town)				2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother) State... <u>Md.</u> County... <u>Somerset</u> City or town... <u>Oriole Md.</u> (If outside city or town limits, write RURAL and give nearest town)			
How long in above place of death? Hospital, Institution, or street address where death occurred:				Street No. _____ (If rural, give LOCATION)			
How long in hospital or institution?				2.(a) If veteran, name war... <u>None</u>			
3.(a) FULL NAME <u>Isaac Henry Hickman</u>				3.(b) Social Security Number <u>218-05-8778</u>			
4. Sex <u>Male</u>	5. Color or race <u>white</u>	6.(a) Single, married, widowed, or divorced <u>Married</u>					
6.(b) Name of husband or wife... <u>Harriet E. Hickman</u>				MEDICAL CERTIFICATION			
7. Birth date of deceased (mo., day, yr.) <u>May 8, 1883</u>				20. DATE OF DEATH <u>March 23</u> 1945, at <u>11:50AM</u>			
7. (c) If alive, give age... <u>57</u> years				21. I CERTIFY that death occurred on the date above stated; that I attended deceased from <u>April 16</u> 1945, to <u>March 23</u> 1945 and that I last saw him alive on <u>March 6</u> 1945			
8. AGE: Years <u>61</u> Months <u>10</u> Days <u>15</u> If less than one day hrs. min.				Immediate cause of death <u>Carcinoma of Stomach</u>			
9. Birthplace... <u>May 8, 1883</u> (Town, county, and state)				DURATION <u>1 year</u>			
10. Usual occupation... <u>Farmer</u>				Due to...			
11. Industry or business <u>Truck Farming</u>				Due to...			
12. Name... <u>William Hickman</u>				Other conditions <u>Arterio sclerosis</u> <u>Heart Disease</u>			
13. Birthplace <u>Oriole Md.</u>				(Include pregnancy within 3 months of death)			
14. Maiden name... <u>Charlotte Phoebe</u>				Major findings of operations...			
15. Birthplace <u>Oriole Md.</u>				Date of op. ....			
16. Informant... <u>Mrs. Cheye Morris</u>				Autopsy results...			
Address <u>Princess Anne Md.</u>				PHYSICIAN: Please underline the cause to which death should be charged statistically.			
17. Burial (Birth, cremation, or removal. Which?) <u>Buried</u> Date thereof <u>March 25, 1945</u> (month) (day) (year)				22. VIOLENCE: If death was due to external causes, fill in the following: Accident, suicide, or homicide..... Date of .....			
Cemetery or crematory... <u>St Andrews</u>				Where did injury occur? ..... (City or town) ..... (County) ..... (State)			
Location <u>Princess Anne Md.</u>				Injured at home, farm, industry, public place (where?) .....			
18. Funeral director... <u>Dale Dashell</u>				Means of Injury ..... Injured at work? .....			
Address <u>Princess Anne Md.</u>				23. SIGNATURE <u>Frank Matus</u> M. D. or other Date rec'd by registrar <u>Mon 20 1945</u> <u>Dr. S. Bonelli</u> Date signed <u>3/28/45</u>			
19. (Date rec'd by registrar)				Address <u>Princess Anne Md.</u>			



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physician H. Please write the causes of death clearly and legibly.

Evidence for addition of MARYLAND STATE DEPARTMENT OF HEALTH  
residence of deceased is shown on 2411 N. Charles St., Baltimore 3d

03201

268

## CERTIFICATE OF DEATH

Reg. Dist. No.

FILE NO G 94 MAY 15 1945

## 1. PLACE OF DEATH:

County Somerset Co.

City or town Venton, Md.

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? Lifetime

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

## 3. (a) FULL NAME

Alexander Holbrooke

4. Sex

5. Color or race

6. (a) Single, married, widowed, or divorced

m Colored Married

6. (b) Name of husband or wife Mary Grace Holbrooke

7. Birth date of deceased (mo., day, yr.)

March 30, 1872

8. (c) If alive, give age years

8. AGE: Year Month Days If less than one day hrs. min.

72 11 27

9. Birthplace Venton, Md.

(Town, county, and state)

10. Usual occupation Farmer

11. Industry or business

12. Name Stanley Holbrooke

13. Birthplace Somerset Co.

14. Maiden name Ella Hitch

15. Birthplace Somerset Co.

16. Informant George Thomas Maddox

Address Venton, Md.

17. Burial Date thereof 3-30-1945

(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Venton, Md.

Location Venton, Md.

18. Funeral director William Jones &amp; Son

Address Princess Anne, Md.

19. (Date read by registrar) 3/29/45

19. (Date signed) 3/27/45

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Somerset

City or town Venton (If outside city or town limits, write RURAL and give nearest town)

Street No. Rural (If rural, give LOCATION)

2. (a) If veteran, name war

## 3. (b) Social Security Number

## MEDICAL CERTIFICATION

20. DATE OF DEATH March 26 1945 at 11:30 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Dec 20, 1944, to March 26, 1945,

and that I last saw him alive on March 26, 1945.

Immediate cause of death Pulmonary Tuberculosis

DURATION 4 mos

Due to

Due to

Other conditions

(Include pregnancy within 8 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external cause, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Frank Matushka

M. D. or other

Address Princess Anne Date signed 3/27/45

Registrar



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians, please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 1C

## CERTIFICATE OF DEATH

Reg. Dist. No. 2621

03202

## 1. PLACE OF DEATH:

County ..... Somerset  
 City or town ..... Pocomoke City, RURAL  
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 7 months &amp; 21 days

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

## 3. (a) FULL NAME

Robert Lewis Joyner

4. Sex 5. Color or race 6.(a) Single, married, widowed, or divorced

Male	Colored	Single
------	---------	--------

6.(b) Name of husband or wife.....

7. Birth date of deceased (mo., day, yr.) August 4, 1944

8. AGE: Years Months Days If less than one day  
7 21 hrs. min.9. Birthplace RURAL, Pocomoke City-Somerset-Md.  
(Town, county, and state)

10. Usual occupation

## 11. Industry or business

12. Name John Joyer

13. Birthplace North Carolina

14. Maiden name Mabel Horsey

15. Birthplace Somerset County, Md.

Mabel Horsey Joyner

Address Pocomoke City, Md. # Rt. 1

16. Informant Burial Date thereof Mar. 27, 1945

(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Christ M. E. Cemetery

Location Pocomoke City, Md. Rt. 1

18. Funeral director H. Harvey Bradshaw

Address Pocomoke City, Md.

19. Mar. 27 1945 Mrs Clayton Davis  
(Date rec'd by registrar)

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Somerset

City or town Pocomoke City, RURAL

(If outside city or town limits, write RURAL and give nearest town)

Street No. # Rt. 1

(If rural, give LOCATION)

2.(a) If veteran, name war.....

## 3. (b) Social Security Number

## MEDICAL CERTIFICATION

20. DATE OF DEATH March 26, 1945, at 10 A.M.

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from March 25, 1945 to March 26, 1945,

and that I last saw h. alive on

19

Immediate cause of death

Sudden Collapse

Date to

Due to Brain Hemorrhage

Date to

DURATION

1/2 hr

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide... Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury

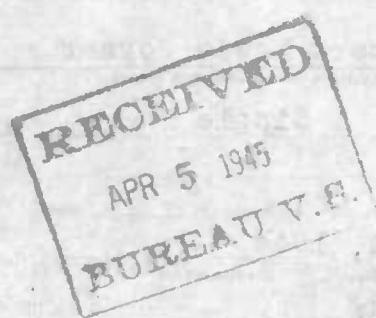
Injured at work?

23. SIGNATURE

John Wilson

M. D. or other

Address Pocomoke City Date signed 3/27/45



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: Please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 26

## CERTIFICATE OF DEATH

03203  
Reg. Dist. No. 265

1. PLACE OF DEATH:  
 County Somerset  
 City or town Crisfield  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death? Life  
 Hospital, institution, or street address where death occurred:  
 How long in hospital or institution?

3. (a) FULL NAME  
 Grace McCready

4. Sex male	5. Color or race white	6.(a) Single, married, widowed, or divorced married
-------------	------------------------	---

6.(b) Name of husband or wife Beatrice McCready

7. Birth date of deceased (mo., day, yr.) Sept. 13, 1889

8. AGE: Years 55 Months 5 Days 18 If less than one day hrs. min.

9. Birthplace Crisfield, Md.  
 (Town, county, and state)

10. Usual occupation Taxi Cab Operator

11. Industry or business self

FATHER 12. Name Frances A. McCready

13. Birthplace Md.

MOTHER 14. Maiden name Nancy B. Whealton

15. Birthplace Va.

16. Informant Beatrice McCready  
 Address 209 N. 1st St.

Burial 17. Date thereof 5/6/45  
 (Burial, cremation, or removal. Which) Asbury  
 Cemetery or crematory

Location Crisfield

Howard H. Hubbard

18. Funeral director 306 Main St., Crisfield, Md.  
 Address

3/5/45 19. Date rec'd by registrar  
 G.E. Collins, M.D.  
 Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:  
 (For newborn infants give residence of mother)  
 State Md County Somerset  
 City or town Crisfield  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No. 209 N. 1st St  
 (If rural, give LOCATION)  
 2.(a) If veteran, name war none

3. (b) Social Security Number none

MEDICAL CERTIFICATION  
 March 3, 1945

20. DATE OF DEATH  
 I CERTIFY that death occurred on the date above stated: That I attended deceased from March 3, 1945 to March 3, 1945  
 and that last saw him alive on March 3, 1945

Immediate cause of death

*Myocarditis*

*Tuberculosis*

Due to

*Pneumonia*

Due to

*Malnutrition*

Other conditions

(Include pregnancy within 8 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

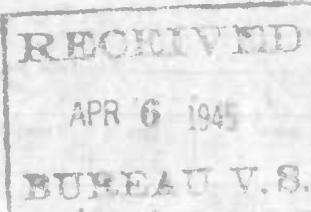
Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE  
 M.D. or other

Address Crisfield - Md. Date signed 3/5/45



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians, please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 2d

## CERTIFICATE OF DEATH

03264

Reg. Dist. No. 260

## 1. PLACE OF DEATH:

County

Somerset

City or town

Princess Anne

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

66 yrs

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

## 3. (a) FULL NAME

Ellen Frances Lusk

4. Sex

5. Color or race

6. (a) Single, married, widowed, or divorced

Fam Colored Widower

B. (b) Name of husband or wife

William R. Miles

6. (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec 12-1878

8. AGE: Years Months Days If less than one day

66 3 11 hrs. min.

9. Birthplace Princess Anne Somerset MD  
(Town, county, and state)

10. Usual occupation House wash

11. Industry or business

12. Name Chas Williamson

13. Birthplace Princess Anne Somerset MD

14. Maiden name Matilda McBrade

15. Birthplace Princess Anne Somerset MD

16. Informant Viola Long

Address Princess Anne PFDI 1nd

17. Burial Date thereof Mar 27-45

(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Oakville

Location Princess Anne MD

18. Funeral director Chas H. Ward

Address Marion Sta. Md.

19. Date rec'd by registrar 3/26 1945

(Date rec'd by registrar)

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State

Md County Somerset

City or town

Princess Anne

(If outside city or town limits, write RURAL and give nearest town)

Street No.

R. F. D. 1

(If rural, give LOCATION)

2. (a) If veteran, name war

## 3. (b) Social Security Number

## MEDICAL CERTIFICATION

2D. DATE OF DEATH March 23 1945 M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Feb 18 1945 to Feb 18 1945

and that I last saw her alive on Feb 18 1945

Immediate cause of death Sudden death

"Sudden death"

Due to coronary sclerosis

Due to generalized arteriosclerosis

Other conditions chronic bronchitis

(Include pregnancy within 8 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

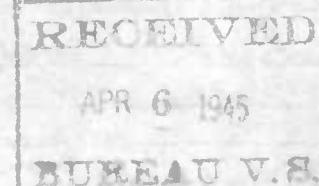
Means of Injury Injured at work?

23. SIGNATURE Frank M. Lusk M. D. or other

Address Princess Anne Date signed 3-23-50

RECEIVED FEDERAL BUREAU OF INVESTIGATION

U. S. DEPARTMENT OF JUSTICE



✓ PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physician

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 1960

03205

## CERTIFICATE OF DEATH

Reg. Dist. No.

269

## 1. PLACE OF DEATH:

County Somerset

City or town Oriole Md

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, Institution, or street address where death occurred:

How long in hospital or institution?

## 3. (a) FULL NAME

Hally C. Ross

4. Sex

F

5. Color or race

W

6.(a) Single, married, widowed, or divorced

married

6.(b) Name of husband or wife

Charles Ross

7. Birth date of deceased (mo., day, yr.)

Dec. 18 1858

6.(c) If alive, give age 61 years

8. AGE:

85

Years

Months

Days

If less than one day

17

hrs.

min.

9. Birthplace

Baltimore Md

(Town, county, and state)

10. Usual occupation

Housewife

11. Industry or business

MOTHER FATHER

William Wyatt

13. Birthplace

Baltimore Md

14. Maiden name

Alysine Hubbard

15. Birthplace

Baltimore Md

16. Informant

Philip Wyatt

Address

Oriole Md

17. Burial

(Burial, cremation, or removal. Which?)

Date thereof

March 10 1945  
(month) (day) (year)

Cemetery or crematory

Monroe Cemetery

Location

Monroe Md

18. Funeral director

Dale Dashiell

Address

Princess Anne Md

19. Date rec'd by registrar

May 10 1945

(Date rec'd by registrar)

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland

County

Somerset

City or town Oriole Md

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war

## 3. (b) Social Security Number

none

## MEDICAL CERTIFICATION

20. DATE OF DEATH

May 7

1945 at 6:00 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

19...

to

and that I last saw h... alive on

19...

Immediate cause of death

Arteria arterios

DURATION

Duration

Due to

Due to

Other conditions

Chronic nephritis

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

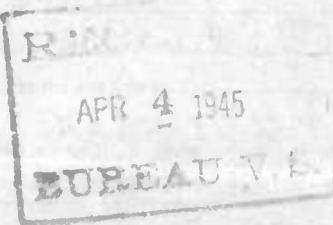
John Smith

James Anna

M. D. or other

Date signed 5/9/45

Address



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: Please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 940

## CERTIFICATE OF DEATH

03206  
265  
Reg. Dist. No.

**1. PLACE OF DEATH:**

County..... Somerset  
City or town..... Crisfield  
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?..... Life

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

**2. USUAL RESIDENCE (HOME) OF DECEASED:**  
(For newborn infants give residence of mother)

State..... Md  
County..... Somerset  
City or town..... Crisfield  
(If outside city or town limits, write RURAL and give nearest town)

Street No..... RFD  
(If rural, give LOCATION)

2.(a) If veteran, name war..... none

**3. (a) FULL NAME**

John F. Sterling

4. Sex male	5. Color or race white	6.(a) Single, married, widowed, or divorced widower	
6.(b) Name of husband or wife..... Hettie L.			
7. Birth date of deceased (mo., day, yr.) January 6, 1863			
8. AGE: Years 82	Months 2	Days 24	If less than one day hrs. .... min.
9. Birthplace..... Crisfield, Md. (Town, county, and state)			
10. Usual occupation..... Farmer			
11. Industry or business..... Self			
FATHER	12. Name..... Hance Sterling Md.		
MOTHER	13. Birthplace..... Harriett Bedsworth Md.		
	14. Maiden name..... Emma Sterling Crisfield, Md.		
	15. Birthplace.....		
	16. Informant.....		
	Address.....		
	17. Burial..... April 2, 1945 (Burial, cremation, or removal, Which) Date thereof..... (month) (day) (year) Cemetery or crematory..... Mariners Location..... Crisfield, Md. Howard H. Hubbard		
	18. Funeral director..... 506 Main St., Crisfield, Md. Address.....		
	19. Date rec'd by registrar..... 3/31/45 19..... 6, E. Collins, M.D. Registrar.....		

**MEDICAL CERTIFICATION**

**20. DATE OF DEATH** Mar. 30, 1945 19..... at 2 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Was Dead When I was Called  
and last saw her alive on

Immediate cause of death..... Coronary Occlusion

Due to.....

Other conditions.....

Witnessed by..... William H. Coulbourn, M. D.

Major findings of operation.....

**DEPUTY MEDICAL EXAMINER**  
**FOR SOMERSET COUNTY, MD.**

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

**22. VIOLENCE:** If death was due to external causes, fill in the following:  
Accident, suicide, or homicide..... Date of.....

Where did injury occur?..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury..... Injured at work?

**23. SIGNATURE**

Spuyt Coulbourn  
Crisfield, Md. 3/31/45  
M. D. or other

Date stamp.....

RECEIVED  
APR 6 1945  
BUREAU V.S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: Please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 2D

## CERTIFICATE OF DEATH

Reg. Dist. No. 0324765

1. PLACE OF DEATH:  
County ..... Somerset  
City or town ..... Crisfield

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? ..... life

Hospital, Institution, or street address where death occurred:

How long in hospital or institution? .....

3. (a) FULL NAME

William A.

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	white	married

6.(b) Name of husband or wife ..... Addie Mae

7. Birth date of deceased (mo., day, yr.) ..... March 11, 1863

8. (c) If alive, give age ..... 76 years

8. AGE:	Years	Months	Days	If less than one day
	82		7	hrs. min.

9. Birthplace ..... Somerset Co., Md.

(Town, county, and state)

10. Usual occupation ..... Retired Auto Salesman

11. Industry or business ..... self

12. Name ..... Josiah Sterling

13. Birthplace ..... Md.

14. Maiden name ..... Catherine DeNight

15. Birthplace ..... Pa.

16. Informant ..... Cullen Sterling

Address ..... Crisfield, Md.

17. burial ..... Date thereof ..... 3/19/45

(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or columbarium ..... Asbury

Location ..... Crisfield, Md.

18. Funeral director ..... Howard H. Hubbard

Address ..... 306 Main St., Crisfield, Md.

19. Date rec'd by registrar ..... 3/19/45

(Date rec'd by registrar) 19 (Year)

2. USUAL RESIDENCE (HOME) OF DECEASED:  
(For newborn infants give residence of mother)

State ..... Md. County ..... Somerset

City or town ..... Crisfield

(If outside city or town limits, write RURAL and give nearest town)

Street No ..... R.E.D.

(If rural, give LOCATION)

2.(a) If veteran, name war ..... none

3. (b) Social Security Number ..... none

## MEDICAL CERTIFICATION

20. DATE OF DEATH ..... March 17, 1945

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

July 14, 1945, to March 17, 1945,

and that I last saw h. J.Y. alive on March 17, 1945.

Immediate cause of death .....

Due to .....

Due to .....

Due to .....

Other conditions .....

(Include pregnancy within 8 months of death)

Major findings of operations .....

Date of op. ....

Autopsy results .....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide ..... Date of ..... (month) (day) (year)

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury ..... Injured at work?

23. SIGNATURE ..... C. E. Galloway M.D.

M. D. or other ..... (Signature)

Address ..... Crisfield, Md. Date signed ..... 3/19/45



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 920

03208

## CERTIFICATE OF DEATH

Reg. Dist. No. 265

## 1. PLACE OF DEATH:

Somerset

County

Crisfield

City or town

(If outside city or town limits, write RURAL and give nearest town)

5 yrs

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

## 3. (a) FULL NAME

Alfred Toulson

4. Sex

5. Color or race

6.(a) Single, married, widowed, or divorced

Male

Negro

Married

6.(b) Name of husband or wife

Josephine Toulson

7. Birth date of deceased (mo., day, yr.)

NOV 3 1896

6.(c) If alive, give age years

47

8. AGE: Years

48

Months

4

Days

4

If less than one day

4 hrs. min.

9. Birthplace

Unknown

Virginia

(Town, county, and state)

10. Usual occupation

Laborer

11. Industry or business

Seafood House

MOTHER FATHER

12. Name

Zeb Toulson

13. Birthplace

? Virginia

14. Maiden name

Sarah Green

15. Birthplace

? Virginia

16. Informant

Josephine Toulson

Address

So. Street, Crisfield Md

17. Burial

Date thereof Mch 11 1945

(Burial, cremation, or removal. Which?)

(month) (day) (year)

Cemetery or crematory

Asbury cemetery

Location

Crisfield Md

18. Funeral director

John A Bradshaw

Address

Crisfield Md

19. Date rec'd by registrar

3/10/45

68 Collins, M.D.

Registrar

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State

Md

County

Somerset

City or town

Crisfield

Md

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (b) Social Security Number  
213-18-4614

## MEDICAL CERTIFICATION

20. DATE OF DEATH

3/7

1945 al LA

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

10/27/44

to

3/17

1945

and that I last saw h.e. alive on

3/6/1

1945

Immediate cause of death

Artificial respiration

Due to Edema

DURATION

10/27/44

3/7/45

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings or operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

W.J. Barkley, M.D.

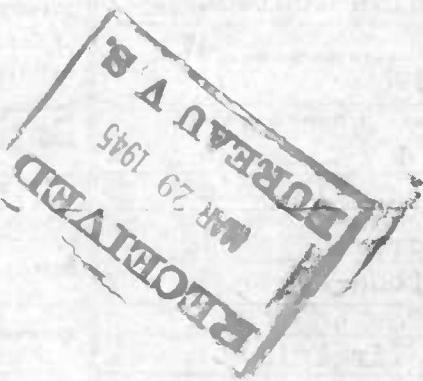
M. D. or other

Address

Crisfield, Md

Date signed

3/10/45



3

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: Please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 93-2

## CERTIFICATE OF DEATH

Reg. Dist. No.

03219

268

## 1. PLACE OF DEATH:

County.....

City or town.....

Somerset  
Chase MD

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?.....

to her

Hospital, Institution, or street address where death occurred:.....

How long in hospital or institution?.....

## 3. (a) FULL NAME

4. Sex

Female estate ill &amp; owned

5. Color or race

6.(a) Single, married, widowed, or divorced

## 6.(b) Name of husband or wife

→ Deceased

7. Birth date of deceased (mo., day, yr.)

March 13 1865

6.(c) If alive, give age years

8. AGE:

Years 80 Months 1 Days 1 If less than one day hrs. min.

9. Birthplace

Chase MD

(Town, county, and state)

10. Usual occupation

Housewife

11. Industry or business

Beneficent Society

12. Name

Benjamin Jones

13. Birthplace

Chase MD

14. Maiden name

Ariana Jones

15. Birthplace

Chase

16. Informant

Edwin Tyler

Address

Chase

17. Burial

Date thereof March 16-45

(Burial, cremation, or removal. Which?)

(month) (day) (year)

Cemetery or crematory

Chase MD

Location

Chase

18. Funeral director

H. Webster

Address

Deals Island

19. Date rec'd by registrar

Mar 16 1945 Rosa Webster

Registrar

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Somerset

City or town Chase (If outside city or town limits, write RURAL and give nearest town)

Street No. (If rural, give LOCATION)

2.(a) If veteran, name war

## 3. (b) Social Security Number

Mary Virginia Taylor

## MEDICAL CERTIFICATION

20. DATE OF DEATH March 14<sup>th</sup> 1945 at 1045 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

and that I last saw h. alive on

Immediate cause of death Arteria Sclerotic

DURATION

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (whers?)

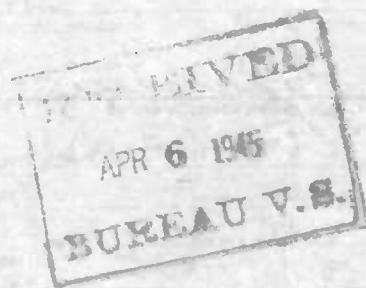
Means of injury Injured at work?

23. SIGNATURE John M. D. or other

Address Patricia Ann D. Date signed

NY 1439-30 THIRTY-NINE STATE CHARTER

STANDARD STATIONERY



**M**  
PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

9321

03219

## CERTIFICATE OF DEATH

Reg. Dlat. No. ....

169

## 1. PLACE OF DEATH:

County *Somerset*City or town *Oxon Chapel Rd*

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

## 3. (a) FULL NAME

*George Wallace*4. Sex *M*5. Color or race *W*6.(a) Single, married, widowed, or divorced *Married*6.(b) Name of husband or wife *Allie M. Wallace*

7. Birth date of deceased (mo., day, yr.)

6.(c) If alive, give age *66* years8. AGE: Years *71*

Months

Days

If less than one day

*16 hrs. min.*9. Birthplace *Oriole Maryland*

(Town, county, and state)

10. Usual occupation *Waterman*

## 11. Industry or business

12. Name *William W. Wallace*13. Birthplace *Oriole Maryland*14. Maiden name *Nettie Wondra*15. Birthplace *Oriole, Maryland*16. Informant *William H. Bedsworth*Address *Oriole, Maryland*17. Burial Date thereof *April 2 1948*  
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or columbarium *J. O. M. Cemetery*Location *Oriole, Maryland*18. Funeral director *Wade Marshall*Address *Princess Anne, Md.*19. Date rec'd by registrar *April 2 1948*19.  
(Date rec'd by registrar)

Registrar

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State *Maryland* County *Somerset*City or town *Oxon Chapel Rd*

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war

## 3. (b) Social Security Number

*None*

## MEDICAL CERTIFICATION

20. DATE OF DEATH *March 31 1948*

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

19. to 19.

and that I last saw h. alive on 19.

Immediate cause of death *arteriosclerosis*

DURATION

*myocarditis*

Due to

Due to

Other conditions

(Include pregnancy within 8 months of death)

Major findings or operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide... Date of...

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

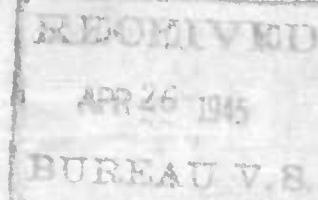
Means of injury

Injured at work?

23. SIGNATURE *R. Smith*Address *Princess Anne, Md.*

M. D. or other

Date signed *4/2-48*



PLEASE WRITE PLAINLY, WITH UNFADING INK,  
Especially important. Physicians: Please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 260

03211

## CERTIFICATE OF DEATH

Reg. Dist. No. 260

## 1. PLACE OF DEATH:

County Somerset  
 City or town Mt Vernon, Md.

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

## 3. (a) FULL NAME

Elden Wallace

4. Sex

5. Color or race

6. (a) Single, married, widowed, or divorced

M Colored married  
Anna Mae Wallace

6. (b) Name of husband or wife

Anna Mae Wallace  
 7. Birth date of deceased (mo., day, yr.) November, 8, 1909

8. AGE: Years 36 Months 4 Days 20 If less than one day

hrs.  min.

9. Birthplace Mt Vernon, Md.

(Town, county, and state)

10. Usual occupation Carpenter

## 11. Industry or business

12. Name Samuel Wallace13. Birthplace Wicomico Co.14. Maiden name Sarah Barrels15. Birthplace Somerset Co.16. Informant Joseph B. WatersAddress Princess Anne, Md.17. Burial Date thereof 4-1-1945  
 (Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory Polk Road, Md.Location Polk Road, Md.18. Funeral director William James & SonAddress Princess Anne, Md.19. 3/31 1945 Delinsh  
 (Date rec'd by registrar) Registrar

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State \_\_\_\_\_ County \_\_\_\_\_

City or town \_\_\_\_\_ (If outside city or town limits, write RURAL and give nearest town)

Street No. \_\_\_\_\_ (If rural, give LOCATION)

2.(a) If veteran, name war

## 3. (b) Social Security Number

220-01-8462

## MEDICAL CERTIFICATION

20. DATE OF DEATH March 28<sup>th</sup> 1945 at 11:30 A.M.21. I CERTIFY that death occurred on the date above stated; that I attended deceased from March 28<sup>th</sup> 1945 to March 28<sup>th</sup> 1945 and that I last saw him alive on March 28<sup>th</sup> 1945.

Immediate cause of death

Acute Gastro Enteritis

Due to

Due to

Other conditions

(Include pregnancy within 8 months of death)

Major findings or operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury

Injured at work?

23. SIGNATURE Elden G. Mayes

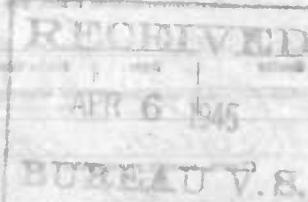
M. D. or other

Address Princess Anne, Md. Date signed 3-30-45

STATE OF THE UNITED STATES OF AMERICA

STATE OF TEXAS

ON DECEMBER



RECEIVED ON APRIL 6 1945

212 24

PLEASE WRITE PLAINLY, WITH UNFADING INK.  
Supply every item of information carefully. The correct age  
is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 18

03212

## CERTIFICATE OF DEATH

Reg. Dist. No. 265

1. PLACE OF DEATH: Somerset Crisfield  
 County.....  
 City or town.....  
 (If outside city or town limits, write RURAL and give nearest town)  
 2 yrs  
 How long in above place of death?  
 Hospital, institution, or street address where death occurred:  
 How long in hospital or institution?

3. (a) FULL NAME John Ward

4. Sex Male	5. Color or race white	6.(a) Single, married, widowed, or divorced Widowed
-------------	------------------------	---

Jane Lane Ward

6.(b) Name of husband or wife.....

7. Birth date of deceased (mo., day, yr.) April 16 1871  
 .(c) If alive, give age years

8. AGE: Years 73 Months 10 Days 3 If less than one day  
 hrs. min.

9. Birthplace Crisfield Somerset Maryland  
 (Town, county, and state)  
 Retired Waterman

10. Usual occupation.....

11. Industry or business

12. Name Charles Ward  
 13. Birthplace Crisfield Md

14. Maiden name Nancy Snead Salisbury  
 Crisfield Md

15. Birthplace MRS Sarah Moore

16. Informant Crisfield Md  
 Address

17. Burial Date thereof Mch 22 1945  
 (Burial, cremation, or removal, which?)  
 Cemetery or crematory Crisfield cemetery

Location Crisfield Md

18. Funeral director John A Bradshaw  
 Address Crisfield Md

19. 3/21/45 19 (Date rec'd by registrar)  
 Address Crisfield Md Date signed 3/21/45  
 Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:  
 (For newborn infants give residence of mother)  
 State N Y County Unknown  
 City or town Richmond Hill  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No.....  
 (If rural, give LOCATION)

2.(a) If veteran, name war.....

3. (b) Social Security Number

MARCH 19 1945 AT 12:00 P.M.  
 MEDICAL CERTIFICATION

20. DATE OF DEATH March 19 1945 at 12:00 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from  
 and that I last saw him alive on

Immediate cause of death was Colled

Heart attack

Due to Fall in Water

Due to Accidental

Other conditions Drowned

(Include pregnancy within 8 months of death)

Major findings of operations

Date of op.

Autopsy results None

PHYSICIAN: Please underline the cause to which death should be charged definitely.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Where did injury occur? Crisfield Md (County)

Injured at home, farm, industry, public place (where?)

Means of Injury

Injured at work?

Signature H. Coulbourn, M.D.

Address Crisfield Md

Date signed 3/21/45

M.D. or other

Address Crisfield Md

Date signed 3/21/45

RECEIVED BY THE ATTORNEY GENERAL

RECEIVED BY THE ATTORNEY GENERAL

RECEIVED  
APR 6 1945  
BUREAU V.S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 130

03213

## CERTIFICATE OF DEATH

Reg. Dist. No. 260

## 1. PLACE OF DEATH:

County Somerset

City or town Westover Md.

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

## 3. (a) FULL NAME

Mary E. Weddowson

4. Sex

F

5. Color or race

W

6. (a) Single, married, widowed, or divorced

widow

B. (b) Name of husband or wife

7. Birth date of deceased (mo., day, yr.) Feb. 24, 1867

6. (c) If alive, give age

years

8. AGE: Years Months Days If less than one day  
18 1 4 hrs. min.8. Birthplace Yonoma Pennsylvania  
(Town, county, and state)

10. Usual occupation Housewife

11. Industry or business

12. Name John S. Roane

13. Birthplace Yonoma, Penna.

14. Maiden name Lucinda Boege

15. Birthplace Yonoma, Penna.

16. Informant Lloyd Weddowson

Address Princess Anne Md.

17. Burial Date thereof March 30 1945  
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Presbbyterian Cemetery

Location Princess Anne Md.

18. Funeral director Dale Dugdale

Address Princess Anne Md.

19. Date rec'd by registrar 3/20 1945

Signature Registrar

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Somerset

City or town Westover Md.

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war

## 3. (b) Social Security Number

## MEDICAL CERTIFICATION

20. DATE OF DEATH March 28 1945 at 12 30 M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

March 25 1945 to March 28 1945

and that I last saw her alive on March 27 1945

Immediate cause of death

Acute Dose of Lead

DURATION

3 days

Due to Central Nervous System

3 days

Due to General Arthritis Relapsing

Cause last respects done regarding

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury

Injured at work?

23. SIGNATURE Guy O. Dorellum M.D.

M. D. or other

Address Somerset Md. Date signed Dec 29 1945

